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ABSTRACT

This document is a report on the implementation of changes to methods formerly used by the Social Security Administration (SSA) to evaluate claims relating to mental impairment for disability benefits. The introductory letter states several conclusions reached by the General Accounting Office's (GAO) review of the criteria used by the SSA to adjudicate these claims: (1) it is too early to measure the SSA's voluntary outreach efforts; (2) progress has been made in staffing disability determination offices with psychiatrists and psychologists; (3) adjudication of claims may need improvement; (4) a growing caseload for examiners may affect the adequacy of future case development; and (5) claimants may not be receiving needed care through medical treatment or rehabilitation. The report includes sections on background information; objectives, scope, and methodology; outreach to previously denied claimants and terminated beneficiaries; and recruitment of psychiatrists and psychologists. Also included is a section on the implementation of new criteria which discusses difficulties in obtaining functional information, the increase in examiner workloads, adequacy of treatment, and referrals to rehabilitation. The report concludes with a set of general observations. Tables and figures are included. The appendix contains 1983 GAO recommendations for SSA actions needed to improve mental disability decisions and the status of psychiatrist/psychologist staffing by state disability determination services as of December 1985. (ABL)

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United States General Accounting Office

GAO

Briefing Report to the Chairman
Special Committee on Aging
United States Senate

May 1996

SOCIAL SECURITY

Implementation of New Mental Impairment Criteria for Disability Benefits

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GAO/HRD-96-75BR

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

May 19, 1986

B-222688

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate

Dear Mr. Chairman:

In a letter of March 8, 1985, you asked us to monitor the implementation of changes to methods formerly used by the Social Security Administration (SSA) to evaluate claims relating to mental impairments for benefits under the Social Security Disability Insurance and Supplemental Security Income programs. These changes were mandated by the Social Security Disability Benefits Reform Act of 1984 (Public Law 98-460).

In later discussions with your office, we agreed to provide you with an assessment of (1) SSA's outreach efforts to contact mentally impaired individuals whose disability benefits had previously been denied or stopped and offer them the opportunity to reapply for benefits, (2) the availability of sufficient psychiatric consultants to assist disability examiners, and (3) implementation by SSA of its new criteria for adjudicating mental impairments. These new criteria consist of changes in the medical listings of mental disorders that are covered by SSA disability benefits programs. SSA is placing more emphasis on acquiring comprehensive medical documentation for prospective claimants and assessing their functional capabilities. Our findings are summarized below and presented in detail in this briefing document.

We did our work between May and December 1985. SSA published its criteria for evaluating mental impairments in August 1985. In addition to working in SSA headquarters in Baltimore, we collected data at four state disability determination service offices in Wilkes-Barre, Pennsylvania, Springfield, Illinois, Austin, Texas, and Oakland, California. We selected these centers because of their relatively large caseloads and geographic differences.

Generally, we observed that:

1. It is too early to measure the effects of SSA's voluntary outreach efforts because the individuals who reapplied will not be identified until the mental impairment cases now backlogged are adjudicated. SSA has made a concerted effort through its regional offices and at the state and local levels to disseminate information to claimants concerning their rights to reapply for benefits.

Also, it has voluntarily sent individual notices to about 25,000 beneficiaries who were terminated from the benefit roles. But, as SSA did not develop a log of those who received the 25,000 notices, it will be unable to identify individuals who did not reapply.

2. Substantial progress has been made in staffing disability determination service offices with psychiatrists and psychologists since our previous review in 1982. As of December 1985, however, 35 states still had not met the goals established by SSA. SSA is continuing to assist the states in their recruitment of psychiatric personnel.

3. While considerable improvements have been made since 1982 in the acquisition and proper evaluation of pertinent medical documentation, early indications are that adjudication of claims may need further improvement. In particular, more detailed information is needed from treating sources on patients' functional capacities and limitations.

4. A growing case workload on examiners may affect the adequacy of future case development. For example, the average national caseload for each full-time examiner increased from 92 in August 1985 to 129 as of January 1986.

5. Claimants may not be receiving needed care through medical treatment or rehabilitation. Our review of 46 cases at the four disability determination service offices visited indicated that in 21 cases the individuals were receiving no medical treatment and in 2 cases treatment was inadequate. In 12 cases, a potential existed for vocational rehabilitation, but most of these claimants were not being referred.

In March 1986, we met with the Associate Commissioner, Office of Disability, and other SSA officials to discuss the contents of this briefing report. The Associate Commissioner said that our observations fairly represented conditions at the time of our work.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this briefing report until 30 days from its issue date. At that time, we will send copies to the Secretary of Health and Human Services and will make copies available to others on request.

For further information, please call me on 275-6193.

Sincerely yours,

J.F. Delfico

Joseph F. Delfico
Senior Associate Director

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ABBREVIATIONS

CDR	continuing disability review
CE	consultative examination
DDS	disability determination service
EIS	early information system
GAO	General Accounting Office
HHS	Department of Health and Human Services
RFC	residual functional capacity
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income

SOCIAL SECURITY: IMPLEMENTATION OF NEW MENTAL IMPAIRMENT CRITERIA FOR DISABILITY BENEFITS

BACKGROUND

In September 1982, we began our initial review of the decision-making process and criteria used by the Social Security Administration (SSA) to adjudicate claims based on mental disability for benefits under the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. We presented our findings in testimony before the Senate Special Committee on Aging on April 7, 1983. Our review focused on individuals whose continuing eligibility for benefits had been reexamined by SSA under the continuing disability reviews (CDRs) mandated by the 1980 Disability Amendments. Many individuals with mental impairments had their disability benefits terminated, we found, despite their severe impairments and, in our opinion, little or no capability to function in a competitive work environment.

This prior review revealed several weaknesses in the adjudicative policies and practices of SSA and the state disability determination services (DDSs). Specific weaknesses we identified and our recommendations concerning them were:

--DDSs were using an overly restrictive interpretation of SSA's criteria (such as basing decisions on very brief descriptions of individuals performing only routine daily activities) to meet the "listing of impairments"[1] for mental disorders. We recommended that SSA undertake a comprehensive study of the criteria used to adjudicate mental impairment cases.

--DDSs were not adequately developing information on and considering claimants' residual functional capacity (RFC) and vocational characteristics.[2] We recommended

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[1]For each body system, such as musculoskeletal and cardiovascular, SSA regulations provide a listing of impairments. Under each listing are alternative sets of symptoms, signs, or laboratory results. When a claimant exhibits one of these sets of symptoms, signs, etc., he or she is presumed disabled.

[2]Residual functional capacity in mental impairments is defined by SSA as a claimant's capacity to understand, carry out, and remember instructions and to respond appropriately to supervisors, coworkers, and customary work pressures in a routine work setting. Vocational characteristics include the claimant's age, education, and work skills.

that SSA appropriately consider claimants' RFC and vocational characteristics before making decisions on mental impairment.

--DDSs were not developing full medical histories in mental impairment cases and were ordering consultative examinations (CEs) before attaining existing medical evidence. (A CE is an examination conducted by an independent physician and paid for by SSA.) We recommended that SSA enforce its policies requiring that a complete medical history be developed on each case before CEs were ordered.

--Neither the DDSs nor SSA had adequate psychiatric resources to assist in the disability decision. We recommended that SSA work with the DDSs to develop a competitive fee structure for hiring more psychiatrists and psychologists.

A more detailed description of these prior recommendations is contained in appendix I.

SSA started taking actions early in 1983 to improve the mental impairment evaluation process. These included the following:

--In January 1983, SSA sent an instruction to DDSs stressing the need to carefully consider individuals' vocational and residual functional capacities in mental impairment cases not decided on medical considerations alone. This memorandum was placed in claims processing manuals in March 1983.

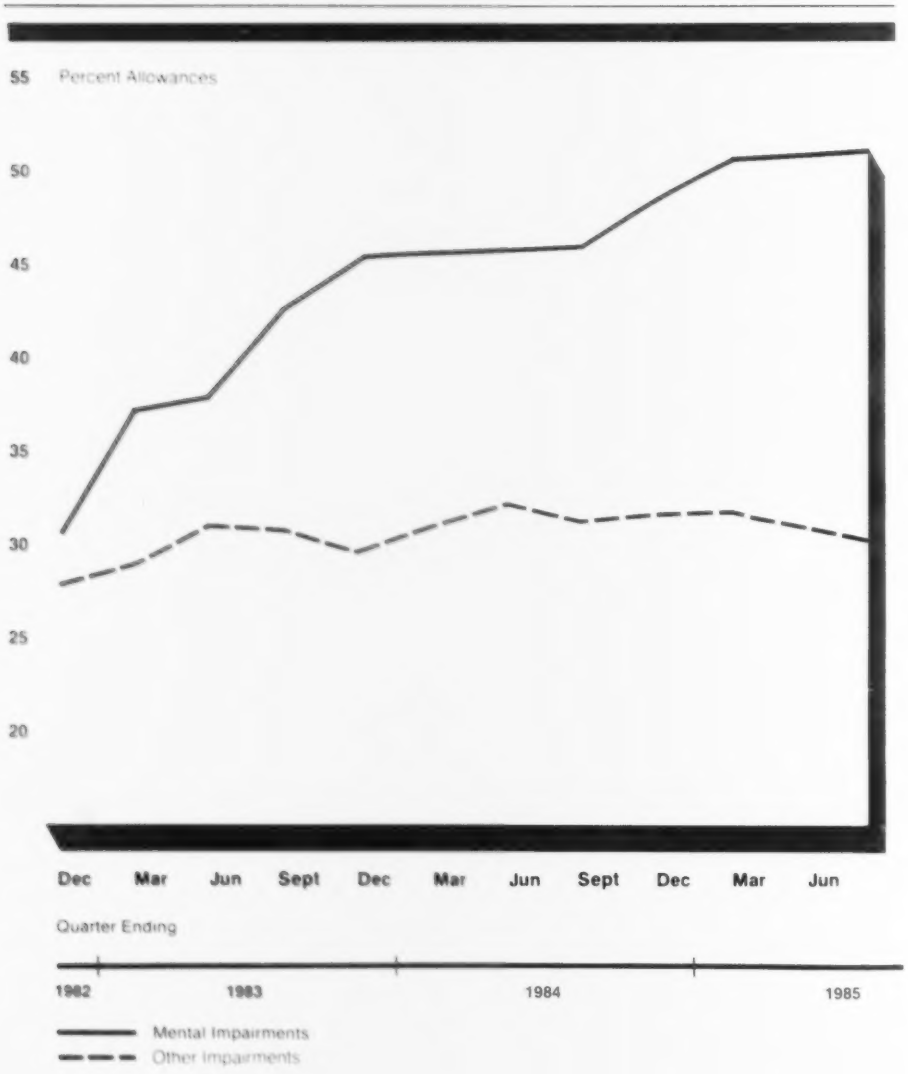
--In April 1983, SSA issued a program circular stressing factors to be considered in arriving at assessments of claimants' RFCs and the role of treating physicians.

--In June 1983, SSA issued a program circular requiring that (1) mental impairments be viewed longitudinally (based on a complete medical history, not merely one point in time), (2) third-party evidence of activities of daily living and unsuccessful work attempts be considered in assessing the severity of the medical impairment, and (3) medical review of mental impairment cases be performed by medical staff with psychiatric training.

These administrative changes had an apparent effect on the mental disability allowance rates, as shown in figure 1. Between December 1982 and June 1985, the initial allowance rate (i.e; before appeal) for claims based on mental impairment for benefits under the SSDI and SSI programs increased from 31 to

51 percent, while the rate for all other impairments remained relatively constant. Allowance rates that reflected the new mental impairment criteria (published in August 1985) were not available as of March 1986. These new criteria emphasize the acquisition of more comprehensive medical documentation and assessment of individuals' functional capacities.

Figure 1:
Allowance by SSDI and SSI Programs of Mental Impairment Claims Versus Other Impairment Claims
(December 1982-June 1985)



Other significant events related to the evaluation of mental impairment claims since the beginning of 1983 include the following:

--In June 1983, the Secretary of Health and Human Services (HHS) announced a temporary moratorium on doing CDRs on about two-thirds of all mental impairment cases--those involving functional psychotic disorders[3]--until new criteria could be developed.

--In July 1983, SSA convened a special workshop to revise its mental impairment criteria for SSDI and SSI, specifically, the listing of impairments and mental disorders. The new criteria were developed with input from representatives from the American Psychiatric Association, the American Psychological Association, and the National Institute of Mental Health, and other experts on mental health.

--On October 9, 1984, Public Law 98-460 was enacted. It directed the Secretary of HHS to revise the mental impairment criteria and issue the revisions through formal regulations. The new law also required SSA to make every reasonable effort to have a qualified psychiatrist or psychologist participate in evaluating mental impairment cases before an unfavorable decision was made.

--On August 28, 1985, SSA published the new mental impairment criteria as regulations.

In June 1986, the American Psychiatric Association, under a contract with SSA, will begin a review of 800 cases adjudicated under the new criteria to evaluate SSA's methods and standards for evaluating mental disabilities.

OBJECTIVES, SCOPE, AND METHODOLOGY

We began our work in May 1985 and completed field work in December 1985. During this time, SSA experienced delays in implementing the new mental impairment criteria required by Public Law 98-460 and did not publish them as regulations until August 1985. At that time, DDSs were instructed to "move" (process for benefits) only initial claims involving mental impairments that

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[3]Functional psychotic disorders, according to SSA regulations, are characterized by demonstrable mental abnormalities without structural changes in brain tissues. They include mood and thought disorders characterized by varying degrees of personality disorganization and accompanied by a corresponding degree of inability to maintain contact with reality, e.g., hallucinations.

would obviously be allowed under both the old and new criteria. The DDSs were to retain cases for which the decision was questionable or which would result in a denial until SSA, through a review of test cases submitted by the DDSs, was satisfied that the state units were able to correctly apply the new criteria. By mid-November 1985, most DDSs had been given permission to process all allowance decisions; by January 1986, all DDSs had been given permission to process both allowance and denial decisions. Our work, therefore, was primarily conducted during this test period preceding full implementation of the new criteria.

Our fieldwork was conducted at SSA headquarters and four DDSs (in Wilkes-Barre, Pennsylvania, Springfield, Illinois, Austin, Texas, and Oakland, California). We selected the DDSs for their relatively large caseloads and geographic differences. The DDS visits took place during October and November 1985. We also interviewed officials from various mental health organizations.

To assess SSA's outreach efforts, we reviewed SSA's notification procedures. We also attempted to determine, through discussions with SSA, DDS, and community mental health officials, the extent to which previously denied or terminated claimants were reapplying for benefits.

To evaluate the DDS staffing of psychiatrists and psychologists, we obtained information on SSA's national staffing goals and progress and discussed recruiting efforts at each of the DDSs we visited.

Finally, to assess the implementation of the new mental impairment criteria, we interviewed SSA officials; attended SSA and DDS training programs; interviewed DDS administrators, examiners, and psychiatric staff; reviewed 46 cases at the DDSs; and discussed some of these cases with DDS examiners and psychiatric staff. Also, we discussed the implementation with officials from various mental health organizations.

OUTREACH TO PREVIOUSLY DENIED CLAIMANTS AND TERMINATED BENEFICIARIES

Early in 1985, SSA voluntarily implemented an outreach program to mentally impaired claimants who were denied benefits or whose benefits were terminated between March 1, 1981, and October 10, 1984. SSA informed claimants that they could reapply for benefits until October 10, 1985, and that their previously unfavorable decisions would be reviewed using the revised mental impairment criteria. Claimants who had been terminated were identified by a manual search of records. SSA began sending notices to the affected individuals in May 1985;

ultimately, about 25,000 notices were sent. A larger group--those denied benefits--could not be individually identified because SSA's automated information system could not identify which of millions of denied claimants had mental impairments. For this latter group, SSA relied on a public notification program, which included sending letters and fact sheets to local groups or institutions representing mentally impaired persons, placing posters in the community, and putting notices in newspapers.

SSA will not know how many of the previously denied or terminated population have reapplied for redetermination until the backlog of mental impairment cases that built up pending implementation of the new criteria has been adjudicated. Some of the previously denied or terminated are part of that backlog, but are not separately identifiable until the cases are reviewed and coded as such. Also, as SSA did not develop a log of those to whom it sent the 25,000 notices, it can only identify those who reapplied. Because it will be unable to identify those who did not reapply, no follow-up will be possible.

There still may be claimants previously denied or terminated who have not reapplied. Officials from one community mental health organization we met with noted that many may either not understand the notices or not want to go through the application and adjudication process again. Also, many may not have been informed of the opportunity. An SSA district office official in San Francisco noted that many mentally impaired people in the area are transient and therefore difficult to locate. At the time of our visit, the district office had been able to locate only 30 percent of about 500 mentally impaired claimants whose more recent denials were subject to automatic rereview under the new criteria (i.e., those denied between the time of the October 1984 legislation and the August 1985 regulations).

RECRUITING PSYCHIATRISTS AND PSYCHOLOGISTS

In July 1983, SSA, in concert with the states, the American Psychiatric Association, and the American Psychological Association, instituted a recruiting program to hire psychiatric consultants. As of December 1985, the DDSs had collectively met about 60 percent of the overall goal established by SSA. The individual DDS goals were based on the anticipated number of mental cases to be adjudicated. Since our last study in 1982, the DDSs have more than tripled the number of psychiatric consulting hours per week. While this is a considerable improvement, a significant shortage relative to program needs still exists. As shown in appendix II, the achievement of goals range from 100 percent in 14 states and the District of Columbia to 26 percent in California. The low achievement in California was due to a state-imposed hiring freeze, which since has been lifted.

None of the four DDSs visited was able to quantify psychiatric needs because of the uncertainty of the number of backlogged cases that will be provided to them by the district offices. All indicated a need for more psychiatric resources to meet current workloads. All the DDSs were actively recruiting except the Oakland DDS, then under a state hiring freeze (now lifted).

Psychiatric shortages had an adverse effect on the decision process, in that some allowance decisions did not receive psychiatric review. Also, examiners lacked a close working relationship with the psychiatrists and at times had to wait several days to get an appointment with one to discuss a case.

IMPLEMENTATION OF THE NEW CRITERIA

The new mental impairment criteria, published in August 1985, essentially consist of changes in the medical listings for mental disorders. Accompanying the criteria are extensive and comprehensive worksheets--a psychiatric review technique form and a mental residual functional capacity form--to be completed by DDS medical consultants at the time the severity of the impairments and the claimant's functional capacity are being evaluated. The new criteria were designed primarily to more realistically evaluate an individual's ability to work and place more emphasis on comprehensive documentation. For example, they emphasize the need to consider the quality of claimants' activities of daily living, as judged by their independence, appropriateness, and effectiveness and how an individual functions over a long period, not only one point in time.

Prior to publication of the new criteria, SSA provided training to SSA regional offices and DDS examiners, psychiatrists, and psychologists on applying the proposed criteria and related forms. SSA also established an early information system (EIS) to assess the effectiveness of program instructions, procedures, and training on the implementation of the criteria. The EIS was designed so that SSA could provide feedback--including additional training, policy clarifications, and questions and answers--to states before giving them the "go ahead" to begin processing disability decisions. By mid-November 1985, most DDSs had been given approval to process allowance decisions under the new criteria, and by the end of January 1986, all DDSs had been given approval to process both allowance and denial decisions.

We visited four state DDSs during this initial phase of the implementation process (October and November 1985) and discussed implementation with examiners and medical staff. Also, we reviewed a few of the cases they had submitted through the EIS.

Since the EIS cases were not randomly selected, we did not attempt to develop a statistical subsample. We requested a mix of cases--allowances and denials--with different mental diagnoses. Our full-time clinical psychologist and mental health advisor reviewed 46 cases from the four DDSs and, as time permitted, discussed some with DDS examiners and psychiatric consultants. Although our sample was not representative, the information gathered during the case review gave us early indications of potential problems.

It was apparent from our case review and our discussions with DDS staff that, compared to our previous review in 1982, case development and evaluation were more thorough. SSA's new mental impairment criteria place more emphasis on medical histories and assessment of functional capacities. The new forms concerning psychiatric review techniques and mental RFC require comprehensive documentation for completion. There are still some apparent weaknesses, however, concerning the development of adequate medical evidence (particularly in regard to claimants' functional limitations and capabilities) and workload pressures resulting from insufficient examiner staffing levels. Also, we found that many claimants were not receiving proper medical treatment or being referred for rehabilitation. We discussed these problems (covered below in more detail) with DDS and SSA officials, and there was general agreement that additional improvements were needed.

Difficulties in Obtaining Functional Information

In our review of the 46 cases and our discussions with DDS staff, we found a problem still exists in adequate documentation of claimants' functional limitations and capabilities. This problem was also the principal one found by SSA in its review of EIS cases.

Discussing this with mental health officials, we were told that treating sources should be able to provide adequate reports on the functional capacities of their patients. In 19 of the 46 cases we reviewed, however, we found inadequate or no reports from treating sources. Of the 46, 30 were currently receiving treatment and should have had significant data relative to the functional area. Of these, however, 11 had inadequate reports and 8 had no current or past reports from critical treatment sources.

Examiners and DDS medical staff said the low fees paid by the DDSs to treating physicians--from $5 to $25 by the DDSs visited--constitute one reason treating sources are reluctant to provide detailed reports. Another reason given was that treating sources are concerned about patient confidentiality. Hospitals, including Veterans Administration hospitals and mental health clinics, were cited as sources of inadequate reports.

There are various efforts underway across the country to train treating sources about the information requirements of the SSA disability programs. The DDS in Springfield, for example, established a training unit in conjunction with the Illinois Department of Mental Health. Six state mental health hospitals are participating. In early 1986, the DDS plans additional training at community mental health clinics. The Virginia Department of Mental Health and Mental Retardation has a 3-year contract with the Institute for Law and Psychiatry and Public Policy at the University of Virginia to train Virginia hospital and community mental health personnel in the information needs of the SSA disability programs. Under this arrangement, an interdisciplinary team consisting of a lawyer, a social worker, and a psychiatrist has trained over 200 mental health workers.

In addition to treating sources, other useful sources of functional information are claimants' relatives, friends, and previous employers. Some DDS examiners, however, expressed reluctance to request information from third-party sources, citing concerns about violating the claimants' privacy. Examiners also told us there is some confusion about when a sufficient amount of third-party information has been collected.

When sufficient information is not available from treating sources and third parties, CEs or workshop evaluations (assessments of an individual's functional capacity in a work setting) must be purchased.[4] Some CEs may have been purchased unnecessarily, we found. Of the 46 EIS cases we reviewed, there were CEs in 35. Our advisor determined that in 12 of these cases the reports from treating sources appeared adequate to make a decision without a CE and in 12 other cases efforts could have been made first to obtain better reports from the treating sources.

Workshop evaluations are rarely used because a DDS lacks clear guidelines concerning when to use them, particularly for adjudicating mental disabilities. Also, DDSs are reluctant to use them because of costs.[5] Of the 46 EIS cases, our advisor identified 6 where such an evaluation would have been helpful in clarifying the disability. Several DDS psychologists and a

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[4]SSA guidelines stipulate that CEs may be purchased to clarify medical findings and diagnosis, obtain highly technical or specialized medical data not otherwise available, resolve a material conflict or inconsistency in the evidence, or resolve the issue of current severity in continuing disability cases.

[5]Workshop evaluations may require several weeks' notice and then take 1 to 4 weeks to complete. Total costs, including claimants' transportation and lodging, can be over $1,000 per claimant.

psychiatrist we interviewed considered workshop evaluations an excellent tool for assessing functional capacities and indicated they would be appropriate in 10 to 20 percent of the cases. SSA has developed new policy guidance for using workshop evaluations for the mentally impaired and plans to submit it soon as a Notice of Proposed Rulemaking.

Examiner Workloads Increase

During our DDS visits, there was concern among the administrators and claims examiners about whether they would be able to satisfactorily accommodate the increased mental impairment workload. Not only were the examiners having problems obtaining adequate documentation on many of such cases they were developing for the EIS study, but there was also a large backlog waiting to be developed once SSA gave the DDSs permission to process them under the new criteria. (The backlog consisted of cases that had come in since the new criteria were published in August 1985 and previous cases denied or terminated under the old criteria to be rereviewed under the new criteria.) Also, large workloads were anticipated with the resumption of CDR cases, suspended in June 1983. Examiners and DDS officials said that, because of increased emphasis on functional documentation and extensive forms to be filled out, the processing time for mental impairment cases under the new criteria was twice as great as for other disability cases. Their individual caseloads were running about 135 to 150 cases, they said, although they considered less than 100 to be a workable level. SSA has not established goals for pending case workloads per full-time examiner.

The growth of examiner caseloads for pending SSDI and SSI claimants nationally and for the four DDSs we visited is shown in table 1.

Table 1:
Average Workload of Pending SSDI and SSI Cases
(National and Four DDSs)

Time period	Average caseload pending per full-time examiner				
		DDS			
	National	Wilkes-Barre	Springfield	Austin	Oakland
Since new criteria published (as of end of month):					
January 1986	129	121	121	133	164
December 1985	128	109	140	146	162
November 1985	128	115	142	142	156
October 1985	121	104	134	123	140
September 1985	103	91	128	115	118
August 1985	92	75	125	104	108
Previous fiscal years:					
1984	88	-	-	-	-
1983	93	-	-	-	-
1982	108	-	-	-	-
1981	66	-	-	-	-

Adequacy of Treatment, Referrals to Rehabilitation Questioned

Of the 46 EIS cases we reviewed, many of the claimants were not receiving medical treatment for their mental impairments because (except for claimants with suicidal tendencies) SSA has no policy or mechanism concerning the medical treatment needs of claimants. We also identified several claimants who could possibly benefit from rehabilitation services, but were not referred.

In 21 of the 46 cases, our mental health advisor determined that the claimants were not receiving psychiatric treatment for their mental impairments, and in 2 others the treatment received appeared inadequate. Some of these claimants, whether allowed or denied benefits, had the potential for improving their functioning or their capacity to become gainfully employed, were mental health and substance-abuse services utilized. We discussed these observations with DDS psychiatric staff. Although they concurred that many claimants were not receiving adequate treatment, they generally did not consider the claimants' need for treatment as part of their responsibilities.

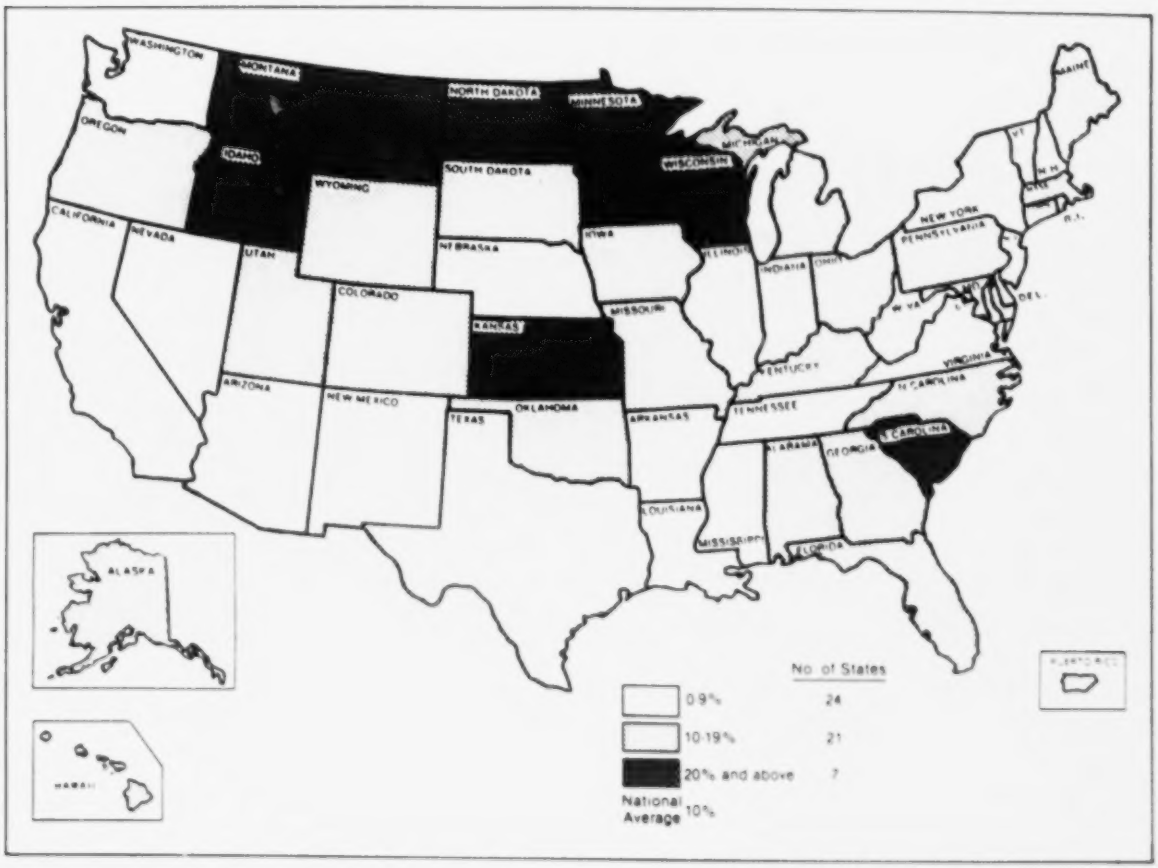
We also discussed the adequacy of treatment with representatives from the National Association of State Mental Health Administrators. They believed that referrals for treatment presented several complicated aspects, i.e., communication between the mental health community and SSA and the rights of individuals. It might be best, they suggested, for SSA and the mental health liaison groups to hold a workshop to examine the issue and arrive at suggestions to get claimants appropriate medical treatment. SSA's Associate Commissioner, Office of Disability, with whom we discussed referrals for treatment, acknowledged the problem and stated that SSA was going to meet with mental health organizations to discuss possible solutions.

With respect to rehabilitation services, in the cases of 12 claimants (10 of them 40 years old or younger), our mental health advisor determined there was potential for some kind of vocational assistance, such as job counseling, training, or retraining, or psychosocial vocational rehabilitation. Most of these 12, however, were not referred by the DDSs to vocational rehabilitation, their files indicated.

In 6 other cases, if the claimants' condition could be stabilized, vocational rehabilitation might have been appropriate, our advisor determined. One reason given by DDS staff for low referral rates was the reluctance of vocational rehabilitation agencies to accept referrals of people with chronic mental impairments.

DDS rates of referral of all impaired applicants to vocational rehabilitation agencies varied widely between the states, as figure 2 shows (data for mentally impaired only were unavailable). The states we visited had lower referral rates than the national average, which was 10 percent in fiscal year 1985. For the four DDSs we visited, the average was 4 percent. States with the highest referral rates included Minnesota, Wisconsin, and North Dakota--54, 37, and 35 percent, respectively.

Figure 2:
Rates of Referrals of Impairment Cases by
State DDSs to Vocational Rehabilitation
(Fiscal Year 1985)



GENERAL OBSERVATIONS

While the development and evaluation of medical evidence in mental impairment claims have significantly improved since early 1983, we found early indications that a number of problems remain. Of particular note are (1) obtaining from private and public treating sources adequate evidence of mental claimants' functional limitations and capacities and (2) helping claimants obtain treatment and rehabilitation.

To accomplish these objectives, state DDSs need sufficient resources. Initial indications from the DDSs we visited are that there may be a shortage of examiners and psychiatric resources to handle the workload.

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ACTIONS NEEDED BY SSA TO IMPROVE MENTAL DISABILITY DECISIONS: 1983 GAO RECOMMENDATIONS[1]

OVERLY RESTRICTIVE INTERPRETATION OF SSA'S MEDICAL CRITERIA

a. A qualified physician should make the assessment of both parts A and B[2] of the medical listings.

b. When a claimant does not meet the listings because he or she does not meet part B, the quality of those activities that keep him or her from meeting part B must be determined and documented--in other words, one positive activity should not be the basis for deciding that the person

--does not have a marked restriction of daily activities,

--does not have a constriction of interest,

--does not have a serious impairment in relating to others, and

--does not have a serious deterioration of personal habits.

c. Because the mental disability criteria have not been revised substantially in many years (1968), we believe SSA should undertake a comprehensive study of the criteria and where study results indicate changes are needed, make them.

RESIDUAL FUNCTIONAL CAPACITY AND VOCATIONAL CHARACTERISTICS ARE NOT APPROPRIATELY CONSIDERED

SSA's new instructions reinforce criteria that we believe are necessary for making accurate mental disability decisions. However, we believe that SSA needs to:

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[1]Unpublished testimony presented by GAO in hearings before the Special Committee on Aging, United States Senate, on April 7, 1983.

[2]The medical listings for mental impairments include parts "A" and "B." The "A" part is the clinical diagnosis of the impairment (e.g., schizophrenic--manifested persistence of one or more of the clinical signs: depression, agitation, hallucinations, etc.). Part "B" assesses an individual's activities of daily living; e.g., ability to relate to others, interest, etc.

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1. Closely monitor the implementation of the new instructions and enforce compliance through the existing assurance reviews and reporting systems.

2. Prepare, periodically, reports on the extent to which evaluation tools called for--i.e., workshop evaluations, etc.--are used in reaching a disability decision.

In addition, we believe that SSA needs to evaluate the vocational characteristics currently used to assess mentally disabled claimants' ability to work, especially the claimants' age. In mental disability cases, age has little direct relationship to a person's ability to realistically function in the "real world of work."

INADEQUATE DEVELOPMENT AND
USE OF EXISTING MEDICAL EVIDENCE

Adequate development of medical information on mental impairment cases is not occurring prior to ordering CEs; in fact, CEs are being used in lieu of developing the full medical history on cases.

SSA needs to enforce its policies that require:

--a full medical history to be developed on each case prior to ordering a CE.

--a CE to be ordered when needed to (1) clarify medical evidence, (2) obtain necessary data not otherwise available, or (3) resolve conflicts or inconsistencies in the evidence obtained.

In addition, when a CE is ordered, the full medical history information should be given to the CE physician to improve the CE physician's ability to accurately evaluate the claimant's condition. Further, when a CE report conflicts with a recent treating physician's report, the CE report should be sent to the treating physician for comment and resolution of the conflict.

We believe the above actions by SSA will result in

1. Savings through the avoidance of unnecessary CEs.

2. Improved medical evaluations of claimants.

3. The potential to augment the severely limited state and SSA psychiatric resources.

STATE PSYCHIATRIC RESOURCES
ARE SEVERELY LIMITED

Because the mental disability decision process encompasses a medical (psychiatric) evaluation that is highly complex, a qualified psychiatrist or psychologist must be involved. However, neither the DDS nor SSA have adequate psychiatric resources to meet this need.

SSA needs to:

1. Work with the states to develop a competitive fee structure for hiring psychiatrists and psychologists or

2. Hire the needed psychiatric resources directly.

In addition, SSA should determine to what extent it can augment limited DDS resources through greater use of treating and CE physicians.

APPENDIX II

STATUS OF PSYCHIATRIST/PSYCHOLOGIST STAFFING BY STATE DDS

(AS OF DECEMBER 1985)

State	No. of staff	Hours worked per week			Percent of SSA goals met by Dec. 1985
		1982	Dec. 1985	Goals	
National	541	2,658	9,937	16,617	60
Alabama	7	55	176	288	61
Alaska	2	15	36	36	100
Arizona	7	108	140	272	51
Arkansas	3	28	100	100	100
California	22	200	490	1,890	26
Colorado	6	42	68	84	81
Connecticut	26	93	308	323	95
Delaware	5	0	42	42	100
District of Columbia	2	0	80	80	100
Florida	19	30	468	678	69
Georgia	17	74	328	443	74
Hawaii	3	7	22	59	37
Idaho	4	0	40	40	100
Illinois	19	12	328	1,236	27
Indiana	12	0	320	476	67
Iowa	6	8	90	105	86
Kansas	9	42	110	110	100
Kentucky	12	30	296	313	95
Louisiana	10	45	178	250	71
Maine	4	0	56	64	88
Maryland	9	15	100	117	85
Massachusetts	25	335	490	550	89
Michigan	19	160	496	860	58
Minnesota	8	42	140	288	49
Mississippi	12	0	172	250	69
Missouri	13	42	222	392	57
Montana	2	6	28	28	100
Nebraska	3	14	51	51	100
Nevada	4	40	66	93	71
New Hampshire	4	10	48	48	100
New Jersey	6	154	126	300	42
New Mexico	5	0	78	78	100
New York	37	378	780	908	86
North Carolina	13	20	368	500	74
North Dakota	4	1	13	13	100
Ohio	40	132	556	1,148	48
Oklahoma	3	12	35	70	50
Oregon	8	21	128	128	100
Pennsylvania	12	0	204	491	42
Puerto Rico	12	139	189	431	44
Rhode Island	9	28	76	102	75
South Carolina	7	0	224	320	70
South Dakota	2	2	22	30	73
Tennessee	16	26	280	409	68
Texas	8	182	320	720	44
Vermont	7	12	60	75	80
Virginia	18	33	257	257	100
Washington	15	20	300	300	100
West Virginia	8	0	127	232	55
Wisconsin	10	35	260	484	54
Wyoming	3	1	5	5	100

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